STATE
COMPENSATION
INSURANCE
FUND

IN REPLY REFER TO:

December 29, 2003

Mr. Richard P. Gannon
Division of Workers' Compensation
455 Golden Gate Ave., 9th Floor
San Francisco, CA 94102-3660

Dear Dick:

Attached is a summary document describing the State Fund Medical Quality Assessment Program (MQAP). Our program has been recently modified to comply with the 2003 legislative reforms. We are confident that implementation of this program will set a standard for the WC insurance industry in terms of controlling the medical costs in the system. This will result in better outcomes for injured workers and increased cost-efficiency for employers.

If you have any questions or comments, please do not hesitate to contact me.

Sincerely,

Gideon Letz, MD, MPH
Medical Director
State Compensation Insurance Fund

1275 Market Street • San Francisco, CA 94103-1410
Mailing Address: P.O. Box 420807 • San Francisco, CA 94142-0807

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MR. RICHARD P. GANNON
DIVISION OF WORKERS' COMPENSATION
455 GOLDEN GATE AVE., 9TH FLOOR
SAN FRANCISCO, CA
94102-3660

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Utilization Review Program

STATE COMPENSATION INSURANCE FUND

Revised 1/1/2004

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I. Introduction

Mission Statement

The State Fund's Utilization Review Program is founded on the principle that appropriate medical care for work-related injury and illness improves medical outcomes while containing costs. Quality medical care for injured employees is enhanced through timely communication and education between State Fund and the medical provider. Medical consultants ensure that medical care is consistent with evidence-based practice, and meets current peer-reviewed medical standards and guidelines.

State Fund is currently piloting and committed to implementing a Disability Management Program, including risk assessment and worksite interventions to facilitate Early Return to Work. We believe this will improve the overall quality of care and reduce utilization costs.

Objectives

1. Reduce costs by eliminating unnecessary, inappropriate medical treatment.

2. Deliver timely responses to physician requests for treatment authorizations.

3. Reduce temporary disability costs by promoting Early Return to Work and use of transitional duty for the injured employee.

4. Improve communication with the medical community.

Scope

This document primarily addresses State Fund's utilization review program. The utilization review process applies only to accepted claims.

II. Definitions

Utilization Review

Labor Code §4610(a) defines "***utilization review***" to mean utilization review or utilization management functions that:

- Prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny

- Based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in LC §3209.3
- Occur prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to LC §4600.

Prospective review - A medical review of a request for health care treatment or services that has not been provided. Prospective approval, or preauthorization, allows the insurer to assess the reasonableness and medical necessity of treatment before the care is rendered

Concurrent review - A medical review of a request for an extension of health care treatment or services beyond previously approved. Concurrent review facilitates ongoing treatment of the injured employee without delay or interruption during the review process.

Retrospective review - A payer initiated medical review of health care treatment or services after the care has been given, where there has been no prospective or concurrent review.

Medical Necessity

The following themes describe what is considered `medically necessary', `reasonable and necessary,' or `medically appropriate'. The procedure, test, or service is:

- The medical care is necessary to cure or relieve the effects of the injury.
- Safe and effective;
- Consistent with the recipient's symptoms, diagnoses, condition, or injury;
- Meets the prevailing standard for medical care, as outlined in the ACOEM or other accepted evidenced-based guidelines.
- Likely to provide a clinically meaningful benefit;
- Likely to produce the intended health result;
- Likely more effective than more conservative or less costly services;
- Enables a patient to make reasonable progress in treatment.
- Provided not only as a convenience to the patient or the provider;
- The benefit outweighs any risk.
- Reasonably expected to diagnose, correct, cure, alleviate or prevent worsening of illnesses or injuries;
- Is not investigational.

III. Program Requirements

State Fund provides telephone access for physicians to request authorization for health care services. The UR PROGRAM is:

- Evaluated at least annually, and updated if necessary.
- Developed with involvement from actively practicing physicians.
- Disclosed by the employer to employees, physicians, and the public upon request.
- Disclosed to the physician and the injured employee, if used as the basis of a decision to modify, delay, or deny services.

Spine Surgery –Mandatory Review

The Claims Adjuster shall refer all spinal surgeries directly to Blue Cross of California (BCC) for utilization review. The BCC UR Service meets the appropriate process and timeframes for decision-making and notification. Once the referral has been made, BCC will notify the provider directly regarding the UR decision and will also inform the Claims Adjuster.

Other Referrals to Outside UR Vendors

State Fund may use the services of outsourced vendors of utilization review services to supplement the in-house UR program. All outsourced UR services are in strict compliance with California law and meet the highest standards of quality in decision-making.

IV. Program Structure

State Fund uses in-house and outside medical professionals to provide UR Services

The Medical Director

State Fund's Medical Director is responsible for oversight of all utilization review activities and ensures that the utilization review process is followed in accordance with this document. The Medical Director is a board-certified occupational medicine physician who holds an unrestricted license to practice in California. In addition, a staff of three masters-prepared occupational health nurses, (two Adult Nurse Practitioners, one OH Administration), are dedicated to the UR PROGRAM.

District Office Health Consultants (DOHCs)

In-house health consultants provide the majority of State Fund's utilization review and utilization management services. The following California-licensed medical professionals conduct UR at the District Office:

- **District Office Nurse Consultant (DONC),** Registered Nurse

- **District Office Physical Therapy Consultant (DOPT),** Registered Physical Therapist
- **District Office Chiropractic Consultant (DODC),** Doctor of Chiropractic
- **District Office Medical Consultant (DOMC),** Medical Doctor, M.D. or Doctor of Osteopathy, D.O

Medical Specialty Panel

Board-certified specialists are available to the DOMC and DODC to advise on case-specific medical issues. The DOMC / DODC shall review all cases before making the referral. The DOMC and Specialist may share information informally, or the specialist may provide a written opinion.

V. Utilization Review Process

When conducting all forms of UR, the following shall apply:

- Only the medical information reasonably necessary to make the treatment decision shall be requested.
- Only a physician competent to evaluate the specific clinical issues, which are within the scope of the physicians practice may modify, delay, or deny treatment.
- A board-certified orthopedic surgeon or neurosurgeon shall review spinal surgery.

Initial Review of the Treatment Plan

UR decisions must be based upon the presence of a valid causal relationship between the claimed injury and the treatment request. Effective medical management therefore begins with the injured employee's first visit for treatment of an injury. Appropriate initial evaluation, diagnosis, and the setting of treatment goals and treatment plan with the injured employee promotes early return to work and functional recovery.

Referral to District Office Health Consultant

DONC/DOPT

The District Office Nurse Consultant (DONC) or the District Office Physical Therapist (DOPT) performs the initial medical assessment. Claims Adjusters should make all internal referrals to the DONC or DOPT for initial review.

The DONC or DOPT will provide a recommendation based on his or her assessment of the clinical information, appropriate clinical guideline, and possible discussion with the provider. The decision should be completed within the appropriate timeframe in the event that further review is necessary. The DONC or DOPT may accept the request for medical treatment, or may negotiate an agreed-upon change with the provider.
The DONC or DOPT may not delay, deny, or reduce the services based upon medical necessity

DOMC/DODC

If the DONC is not able to recommend authorization based on the available information, the request should be forwarded to the DOMC or DODC for further review.

Any delay, denial or reduction of services based upon medical necessity must be reviewed by a physician. Only a physician competent to evaluate the specific clinical issues, which are within the scope of the physician's practice, may modify, delay, or deny treatment plans.

The DOMC or DODC may contact the provider to discuss the case.

Specialty Panel

In cases requiring consultation with a specialist, the DOMC or DODC will initiate contact with a specialist from the Specialty Panel set up for this purpose.

Documentation of Decisions

All DOHCs should clearly and concisely document their activities and decisions in writing on the appropriate State Fund forms designed for that purpose.
(*See attachments, the DOHC UR Referral and DOHC Assessment forms.)*

Decision Timeframes

All decisions must be made in a timely fashion after receipt of the information reasonably necessary to make the determination. Decision timeframes depend upon the type of utilization review conducted, as described below.

Prospective or Concurrent Reviews

For prospective or concurrent reviews, a decision must be made in a timely fashion that is appropriate for the nature of the employee's condition,

- Not to exceed five (5) working days from the receipt of the information reasonably necessary to make the determination,

- But in no event more than fourteen (14) days from receipt of the *initial* medical treatment recommendation.

All UR determinations for prospective or concurrent review must be communicated to the requesting physician initially by telephone or facsimile within 24 hours of the decision. Additional requirements apply:

For concurrent review, a decision to modify, delay, or deny all or part of the request must be communicated in writing to the physician and employee within 24 hours of the decision.

For prospective review, a decision to modify, delay, or deny all or part of the request must be communicated in writing to the physician and employee within two (2) business days of the decision.

Imminent and Serious Threat

In the case employee faces an imminent and serious threat to his or her health; a decision must be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of all necessary information.

Retrospective Review

For retrospective reviews, a decision must be communicated within 30 days of receipt of information that is reasonably necessary to make the determination.

UR Letters & Notification Requirements

Claims Adjusters shall only use State Fund's *Utilization Review Response Letter template* for communication of UR results to providers. Decisions to approve, modify, delay, or deny treatment recommendations by a physician must be communicated as follows:

Approval

An oral communication by Claims Adjusters is sufficient if treatment is approved (i.e., written notice not required), as long as the decision is clearly documented in the claim file. Be specific as possible about the service that has been approved.

Delay

The DOMC or DODC must complete a *DOHC Assessment Form* that includes:

- the reasons for the decision,
- a description of the criteria or guidelines used, and
- the clinical reasons for the decision.

If a delay (inability to meet timeframes) is necessary because of

- missing information **already requested,** or
- there is a need for a consultation by an expert reviewer, or
- we have scheduled an additional examination or test,

A written notice must advise the treating physician and employee of the reason for the delay and the estimated time before a decision is reached. The Claims Adjuster shall attach the completed *DOHC Assessment Form* to the UR Response Letter.

Denial

The DOMC or DODC must complete a *DOHC Assessment Form* that includes:

- the reasons for the decision,
- a description of the criteria or guidelines used, and
- the clinical reasons for the decision.

The Claims Adjuster shall attach the completed *DOHC Assessment Form* to the UR Response Letter.

Modification

Modification refers to a change made in the treatment plan, based upon medical necessity. It does not refer to negotiated changes that are agreed upon. If the DOMC or DODC modifies the treatment request, he or she must complete a *DOHC Assessment Form* that includes:

- the reasons for the decision,
- a description of the criteria or guidelines used, and
- the clinical reasons for the decision.

Treatment Guidelines

The UR Program process requires objective medical references to benchmark expected treatment patterns in common work-related injuries and illnesses. DOHCs shall use

evidence-based treatment guidelines. Only State Fund approved clinical guidelines should be used in the UR process. State Fund guidelines are:

- Consistent with American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines (ACOEM), prior to the schedule adopted by AD,
- Consistent with medical treatment utilization schedule adopted by the AD (Due by December 1, 2004)

If the ACOEM Guidelines or AD schedule is not applicable, other evidence-based medical treatment guidelines generally recognized by the medical community shall be used. Until adoption of Guidelines by the AD, the interim UR guidelines must be:

- Developed by practicing physicians
- Consistent with the medical treatment utilization schedule adopted by the AD (or ACOEM treatment guidelines prior to adoption)
- Evaluated annually
- Disclosed to the treater and the injured employee
- Publicly available

The State Fund is continually expanding reference resources for use by Claims and in-house consultants. The State Fund Medical Director's office acts as a clearinghouse for treatment guidelines and other references providing reliable, valid, current information.

UR Appeal

The treating physician may request review of the medical treatment by a State Fund Specialist Consultant. The DOMC or DODC should arrange this review.

Should the course of treatment continue to be at issue, review may be sought by the State Fund Medical Director.

UR Dispute Resolution

When a medical treatment decision is disputed, the issue will be resolved through Labor Code §4062 per statutory requirements.

Other System Components

The UR Program is an important component of the State Fund's integrated managed care system. Other components include the State Fund/Kaiser Alliance, the State Fund Preferred Provider Network, and the California Medical Association (CMA) accredited Continuing Medical Education program. All are designed to improve the quality of care in a cost-effective manner for injured employees.

Interface with Other Managed Care Activities

When a Disability Management Specialist (DMS) is involved on a Catastrophic claim, that Specialist may approve providers' requests for preauthorization in compliance with this document. However, any delay, denial, or modification of the treatment plan must be referred to a physician for a decision.

Summary

The UR PROGRAM provides timely review of proposed treatment and ongoing care, consistent with evidenced-based treatment guidelines. It also enhances communication with the provider and facilitates transitional duty and return to work arrangements to achieve optimal outcomes of quality and cost-efficiency.

VI. Forms: UR Referral & DOHC Assessment

Medical Treatment Request/UR Referral

☐ Prospective ☐ Concurrent ☐ Retrospective ☐ Litigated

Claim No. _____ PY: _____ Injured Employee's Name: _____ Working? ☐ Yes ☐ No

Adjuster: _____ Accepted Body Part(s): _____

Date Request Received: _____ Date Referred to DOHC: _____

Provider Name: _____ Provider Type/Specialty: _____

Provider's Phone No.: _____ Contact Person: _____

Procedures Requested	Procedures Authorized	Initials

☐ **Adjuster** (Please complete this section for approval only)

☐ **DONC** ☐ **DOPT** **Date Referral Received:** _____

☐ Approved ☐ Unable to Approve (*Must refer to physician reviewer)*

☐ Negotiated *(Describe):* _____

Reason for Decision: _____

_____

_____

_____

_____

Name: **Phone No.:**

☐ **DOMC** ☐ **DODC** **Date Referral Received:**

☐ Approved ☐ Delay *(attach completed UR Assessment form)* ☐ Modify *(attach completed UR Assessment form)*

☐ Deny (*attach completed UR Assessment form)*

Reason for Decision: _____

_____

_____

_____

_____

_____

Name: **Phone No.:**

Adjuster Date Stamp	DONC/DOPT Date Stamp	DOMC/DOPT Date Stamp

STATE COMPENSATION INSURANCE FUND

DISTRICT OFFICE HEALTH CONSULTANT ASSESSMENT

Date: June 10, 2004

To: **Injured Employee Name:**

Title: **Claim Number:** **PY:**

Medical issue:

Assessment of the issue:

Recommendation:

Supporting rationale/references:

Name (printed) Signature

Title Telephone